

**DEVELOPING INTERVENTIONS TO BENEFIT
CHILDREN AND FAMILIES
AFFECTED BY HIV/AIDS:**

**A Review of the COPE Program in Malawi
for the Displaced Children and Orphans Fund**

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NOTES

EXECUTIVE SUMMARY

An extremely poor and densely populated country in southeastern Africa, Malawi is in an advanced stage of an HIV/AIDS epidemic, the impacts of which are already severe and can be expected to become much worse. Child malnutrition is high, and infant mortality, at 126 deaths per 1,000 births, is expected to increase due to HIV/AIDS. Malawi's economy is based on agriculture. The gross domestic product per capita was \$150 in 1994, and about 60% of the predominately rural population of 10 million, fell below the absolute poverty line.¹ About 30% of households are headed by women. The population is about 65% Christian and 16% Muslim. Malawi's citizens are finding new hope and possibilities after multiparty elections in 1994 ended 30 years of oppressive rule. The new government made primary education free, and school enrollment has increased dramatically.

The basic pattern of Malawi's HIV/AIDS epidemic is similar to that seen throughout much of Sub-Saharan Africa. The National AIDS Control Program has estimated that in the 15-49 year age group HIV prevalence is 14%, with rates highest in urban areas. There are indications that HIV infection may have peaked. Even if this is so, AIDS mortality can nonetheless be expected to increase for the next several years.²

In 1992 Malawi established "Policy Guidelines for the Care of Orphans in Malawi," which define an orphan as a child under age 18, one or both of whose parents are dead. Perhaps 10-15% of the country's children meet this definition. In addition to illness, problems in families affected by HIV/AIDS include increased economic stress, psychosocial distress, loss of inheritance by widows and orphans, and orphaning of children and their placement in different households after the second parent's death. Counseling and HIV testing are not common.

To develop and test programmatic responses to the needs of children and families affected by HIV/AIDS, in August 1995 USAID committed \$538,000 from the Displaced Children and Orphans Fund (DCOF) to Save the Children Federation, Inc. of the United States (SC-US). The program is called Community-based Options for Protection and Empowerment (COPE) and has an implementation period of July 15, 1995 - July 15, 1997. Two technical experts visited Malawi October 6-18, 1996, to review COPE in collaboration with SC-US.

COPE is being implemented in Mangochi District, and the periurban Mangochi town area is the initial area of activity. With eight months of funding remaining, COPE staff were preparing to initiate work in another part of the district, Namwera. The program has an elaborate management information system to measure needs as well as its activities and impacts. COPE appears to be essentially on track for achieving the numerical targets for most of its key objectives. The program's main activities are seen positively by the overwhelming majority of the community members and leaders, government personnel and nongovernmental (NGO) staff with whom the team members spoke. COPE staff are dedicated and highly motivated.

Seen, however, in the context of the scope of needs throughout the country, COPE's multiple interventions appear to be too expensive to implement at scale. The team estimated the cost per beneficiary to be \$162 among the program's 704 target households (4,154 members, 58% of whom are children) and proposed alternative approaches to reduce this figure. At the request of the team and to help identify measures that could be implemented at scale, COPE staff began the task of trying to estimate the cost per beneficiary of each of the key interventions of the program.

Microcredit and Gardening

COPE is addressing the critical challenge of increasing household income. Poor households, further economically stressed by AIDS morbidity and mortality, operate in a survival economy and engage in a variety of activities to generate cash for immediate needs, especially food. COPE's responses are a microenterprise credit scheme using village-bank methodology called Group-Guaranteed Lending and Savings (GGLS) and support for gardening on wetlands (dimba) plots. The team discussed with COPE staff the need to recognize the differing compositions and vulnerabilities among households stressed by HIV/AIDS, the significant labor demands they face, their differing capacities to take part in COPE's economic initiatives, and the potential value of interventions that help reduce labor demands. The team also stressed that COPE's economic initiatives must be tailored to the survival economy where target households are operating, rather than to higher levels of micro- and small-enterprise activity. There is evidence that credit can help improve food security and that strengthening income-generating capacity among relatively less-poor households can enable them to assist the most vulnerable community members.

GGLS solidarity lending and savings involves women because female-headed households are often vulnerable and women are likely to use any additional income to benefit their children. In many other situations, women's microcredit has proved to be sustainable and effective in improving food security. In the GGLS scheme, groups of 15 to 20 women are provided with small loans to start or strengthen small enterprises. They receive some training from SC-US and a single loan, which the group on-lends in amounts averaging K1,000 (\$67) to each member for her individual business. The size of the loans is kept small to attract the poorest households. The group is collectively liable for the loan, which must be fully repaid before subsequent credit is released. COPE is also providing some households with tools, agricultural inputs, and training to start or expand gardening on land to which households already have access.

As of the end of September 1996, 343 individuals had participated in GGLS (292) or gardening (51); the target is 500. It was also projected that 200 of the primary-target households would increase their economic resources COPE is completing an instrument to measure progress against this objective.

COPE's economic interventions are reaching 36% of the targeted households. It is not yet clear whether these interventions have made sustainable improvements in the economic situation of the primary-target households. During interviews, GGLS members and dimba gardeners said the quality of the food they were able to buy had improved as a result of their joining the program. However, there were indications that COPE's economic interventions are not reaching (and may not be possible for) the most vulnerable households, whose labor capacities are extremely limited. Community support, rather than participation in an income-generating activity (IGA), may be the best hope for aiding such households. In comparison with other NGO credit programs in Malawi, GGLS appears to be reaching the deepest into the survival economy.

The team suggested that COPE staff consider some modifications in GGLS. This included (1) having groups make their own repayment and savings deposits at the post office; (2) experimenting with the screening of potential group members; (3) stressing the rules and responsibilities of GGLS over basic business skills in pre-loan training; (4) using the last weekly session in a loan cycle to find out what women believe has contributed to the success of their businesses; and (5) catalyzing the formation of community-based organizations that could create a sustainable safety net for the most vulnerable households. Such groups could carry out periodic fund-raising events (rather than ongoing income-generating activities, which tend to become all-consuming) to generate cash to assist vulnerable children and families.

Health Activities

COPE's primary health intervention has been to train caregivers (village residents caring for sick family members) and community volunteers in treating common ailments and making patients as comfortable as possible. Through contacts with village leaders COPE staff identify households with seriously ill members and invite caregivers to participate in a three-day group training session. Staff make regular home visits to assess the quality of care and suggest improvements. They have also built village-level networks of caregivers and trained volunteers, through which participants support each other and share resources. Leaders and residents in target villages indicated that the skills gained through this training are highly valued. At present, training for home-based care addresses only physical care issues.

The home-based care training provided by COPE appears to be having a very positive impact. Patients in households with a trained caregiver are able to live more comfortably and with greater dignity, which should have positive, indirect benefits for their children. As of the end of September 1996, 201 primary-target household caregivers had been trained in home-based care; the target is 500. Unless a different approach is taken, it does not appear likely that the target will be reached by the end of the program's current period of funding. In addition, 257 other people (e.g., religious leaders, community volunteers) have been trained in home-based care, and 15 home-based care trainers have been trained. Care for seriously or chronically ill patients has

been measurably improved in 95 primary-target households. The target for this indicator is 100. Thirty-nine primary-target children had been referred to under-five clinics and 45 to the hospital.

Suggestions the team made for improving home-based care included (1) broadening its scope to address the psychosocial distress of patients and their children; (2) informing households about inheritance issues; and (3) either arranging for hospital staff to make referrals to COPE or, preferably, initiating training while patients are still at the hospital.

Promoting Children's Psychosocial Well-being

COPE has secured donations on a matching-fund basis for secondary school expenses of adolescents from primary-target families and supported structured recreation, drama groups, and skills training linked with other Non-formal education. Structured recreation involves the largest number of participants and has included soccer, netball, traditional games, songs, dance, drawing, and drama. Activities are open to all children in a community, but COPE field workers have made special efforts to involve children from primary-target families. Participation should increase their social integration and allow those who have suffered losses and hardships to express pent-up emotions and increase a sense of control in their lives.

Children and youth have also formed drama groups that sensitize and inform residents about problems among widows and orphans, respect for traditional values, the importance of school, AIDS prevention, civic education, and other topics. One group has charged admission for its performances and used a third of the proceeds to buy soap and provide small amounts of cash to patients receiving home-based care. The skills training component of COPE has been its slowest activity to get off the ground. Funds for skills training have been provided by the United Nations Development Programme (UNDP). With current funding, a group of girls is meeting, a second group took part in a two-week training in weaving, and a group of boys is completing training in automobile repair under funding from 1995.

Scholarships have been provided to 94 of a targeted 100 secondary school students, the most tangible benefit of the program's psychosocial activities. Of the 3,000 children targeted for structured recreation activities, 2,268 have been involved. Of those involved, 562 (25%) were children from primary-target households; the target for this group is 1,000. Forty-three of 50 targeted adolescents have participated in vocational training.³

The team suggested that SC-US either find a civic organization or national NGO to take on the scholarship activities or maintain it as an ongoing SC-US program. The team expressed the belief that structured recreational activities would be more sustainable if COPE's role was to facilitate their organization by community members and if activities were limited to those with inexpensive inputs. The team also proposed a different approach to skills training.

Advocacy and Training

SC-US staff have sought, through advocacy and training, to influence the ways other bodies respond to the needs and problems of children and families affected by HIV/AIDS. COPE has played an active role in the development of the government's "Orphan Care Program: 1996-1998." Its staff's participation in the National Task on Orphans has helped that body orient its policies toward community-based action, and COPE staff have sensitized businessmen and members of parliament about needs and problems in the target communities and sought their support for scholarships. The original COPE proposal calls for a national conference to examine effective ways to support community efforts to aid HIV/AIDS-affected children and families, but it is not clear whether sufficient funding will be available for this effort. COPE has an intern who has begun to work with other organizations in Malawi to explore how the inheritance rights of widows and orphans might be protected.

COPE has secured cash or in-kind contributions from nine of a targeted 20 private-sector institutions and individuals. COPE has trained 123 of a targeted 200 government service providers and policy makers, NGO staff, and community members in children's psychosocial development. Though advocacy with the Ministry of Education, COPE has also secured admission to government schools for 14 COPE students who had originally been admitted to more expensive private schools. While recognizing the potential importance of advocacy and training, the team encouraged COPE staff to use careful judgment in determining how to best invest their time and to define a clear, achievable objective before committing themselves to an activity.

Key Programming Issues

The pattern of HIV/AIDS slowly progressing through a community while families adjust to its impacts has three key implications for programming. First, because problems and capacities vary among affected households, no single intervention can be expected to benefit all. Second, ongoing, community-based monitoring is needed to identify the most vulnerable children and households to whom interventions can be directed. Third, the overall level of need can be expected to increase over a period of years and may remain high. Taking this long view, the team was concerned that COPE's impacts are too dependent on the short-term involvement of the program's 11 paid field workers. Sustainability requires catalyzing community-based groups with a commitment to identify, monitor, and support the most vulnerable children and families.

The COPE Senior Project Manager indicated that in Namwera he anticipated working more with existing structures in the communities, such as religious groups, than staff had done in Mangochi. He wants to promote community involvement in needs identification and planning from the beginning as well as a community commitment to address needs and problems and

ownership of the interventions. The team encouraged COPE to explore ways to catalyze and support the kinds of community-based initiatives that UNICEF and the government have proposed, including community-based child care centers and community AIDS committees to respond to the needs of vulnerable people. The team also recognized the dilemma that NGOs face: On the one hand, they understand that genuine community responsibility for and participation in ongoing efforts take time to build and that the resulting activities cannot be predetermined; on the other, to secure funding they must commit themselves to produce specific, measurable results within a relatively short time frame.

The number of children orphaned and families affected by HIV/AIDS in Malawi is very large and will increase substantially for several years. Collaborative efforts are needed to direct financial and material resources to the geographic areas where families are having the most difficult time coping and, within these areas, to the most vulnerable children and households. This effort would be greatly facilitated if data on orphans are collected in Malawi's 1997 census. Such data could be combined with statistics on health and nutrition to identify particularly vulnerable areas. Because the epidemic will continue to evolve, increasing problems in areas previously less affected, periodic monitoring will also be needed. Decisions about geographic targeting must incorporate assessments that involve the people in the most affected areas. Initiatives supported must be effective, sustainable, and relatively low cost. They should build the coping capacities of households, families, and communities; protect and ensure care for the most vulnerable children; and help children prepare to support themselves. Institutional care should be avoided. So far as possible, interventions should be integrated with other efforts to improve conditions in the most affected communities.

Microcredit programs like GGLS offer good promise. Training for home-based care is also a valuable activity. Community-based identification, monitoring, and support of the most vulnerable children are needed. The potential of community-based child care centers should be explored. Recreation that communities can implement inexpensively can have value if special efforts are made to include vulnerable children. Secondary school scholarships, if they can be secured and sustained at a reasonable cost, would also be valuable. Drama groups, which can help raise awareness about needs and problems and convey HIV/AIDS prevention messages, might be part of periodic community-based fund-raising efforts. In addition to programmatic interventions, many indirect but critically important policy, advocacy, and coordination initiatives can be made at the national level to help build an environment in which HIV/AIDS-affected children and families can cope more easily.

COPE staff and the team identified lessons learned. These included the importance of planning community involvement at the beginning of the intervention period, encouraging communities to identify their problems and ways to address them, and developing approaches that can be taken to scale.

Review of the COPE Program

The team's recommendations appear at the end of the report.

LIST OF ACRONYMS AND ABBREVIATIONS

EDZI Toto	anti-AIDS
CBO	community-based organization
CBM	Commercial Bank of Malawi
CGF	credit guarantee fund
COPE	Community-based Options for Protection and Empowerment
DEMAT	Development of Malawian Enterprises Trust
DCOF	Displaced Children and Orphans Fund
GERM	general economic resource measure
GGLS	Group-Guaranteed Lending and Savings
GOM	Government of Malawi
GTZ	German technical assistance agency
IGA	income-generating activity
HIV/AIDS	human immunodeficiency virus/acquired immune deficiency syndrome
logframe	logical framework
MOWCACDSW	Ministry of Women and Children Affairs, Community Development and Social Welfare
MRFC	Malawi Rural Finance Company
NABW	National Association of Business Women
NGO	nongovernmental organization

Review of the COPE Program

PMERW	Promotion of Microenterprises for Rural Women
ROSCA	rotating savings and credit association
SACCO	savings and credit cooperatives
SC-US	Save the Children Federation, Inc. of the United States
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WWB	Women's World Banking

The team wishes to extend special thanks to Stanley Phiri, Senior Project Manager of COPE, and his staff for facilitating its work. Their candor and commitment to making COPE as effective as possible were always evident and made the visit a truly collaborative endeavor. The team members also wish to express their sincere appreciation to the many staff members of nongovernmental organizations and USAID, village residents and leaders, personnel of the Government of Malawi, and UNICEF officers who generously gave time to meet with them and provide information for this report.

INTRODUCTION

An extremely poor country in southeastern Africa, Malawi is in an advanced stage of an HIV/AIDS epidemic, the impacts of which are already severe and can be expected to become much worse. Its citizens are finding new hope and possibilities after multiparty elections in 1994 ended 30 years of oppressive government. Nongovernmental organizations (NGOs) are emerging as citizens explore the new possibilities of voluntary, collective action and struggle to cope with the problems of poverty exacerbated by AIDS.

Malawi is one of the poorest and most densely populated countries on the African continent. It has a population of approximately 10 million and a density of 83 people per square kilometer. Eighty-nine percent of the population is rural, with the overwhelming majority cultivating very small plots.⁴ The country's high fertility rate has resulted in an annual growth rate of about 3.2%.⁵ Population pressure has contributed to deforestation and other environmental degradation. Malnutrition is widespread among Malawi's children, who make up about half of the country's population. Malawi has one of the highest rates of stunting in Sub-Saharan Africa, with about half of all rural children and a third of urban children having low weight for height. Malawi's infant mortality rate, estimated at 126 deaths per 1,000 births in 1994, is expected to increase during 1995-2002 due to AIDS, in spite of health gains in other areas.⁶

The economy is based on agriculture, primarily maize, tobacco, tea, and sugar cane. The country's gross domestic product per capita was \$150 in 1994, and about 60% of the population fell below the absolute poverty line.⁷ Two droughts in the last five years have caused hardship and undermined economic initiatives. Deforestation and soil erosion have become serious problems, and small holders face increasing shortages of wood for fuel and shelter.⁸

Faced with limited economic prospects at home, many Malawians have become migrant laborers elsewhere in the region. Partly as a result, about 30% of the country's households are headed by women. These households are disproportionately represented in the bottom 25% of Malawi's income distribution.⁹ Female literacy is 35%, while male literacy is 60%.¹⁰

The country's largest ethnic group is the Chewa; its language, Chichewa, and English are the principal languages. Other major ethnic groups are the Yao, Nyanja, Tumbuka, Lomwe, and Sena. About 65% of the population are Christian and 16% Muslim, with many practicing traditional animistic rites as well.¹¹

The country experienced a dramatic and peaceful political change in May 1994, when its first multiparty elections were held, ending the 30-year presidency of Hastings Kamuzu Banda. One of the significant changes introduced by the new government, headed by Bakili Muluzi, was free primary education for all. As a result, primary school enrollment increased from 1.9 million in 1993/94 to over 3 million in 1994/95, and the net enrollment rate increased from 55.9% to 95.7%.¹²

A structural adjustment program is reducing the size and economic control of government. State control of agricultural marketing has essentially been eliminated. Rapid changes on the economic front have brought both new opportunities as well as some hardships as small holders seek to adjust. Price inflation has continued to be high, causing economic stress, particularly in urban areas where wages have not adjusted to economic liberalization as rapidly as have the crop prices farmers receive. AIDS is taking a toll among the government professionals who are trying to manage these economic changes.

HIV/AIDS

The basic pattern of Malawi's HIV/AIDS epidemic is similar to that seen throughout much of Sub-Saharan Africa. Heterosexual contacts are the primary route for HIV transmission, and the majority of AIDS cases are among the 20-49 age group. Among adults, females tend to become infected at younger ages than men. Perinatal transmission is the second leading cause of HIV infection. The incidence of AIDS is greater among children aged 0-4 than those aged 5-14.¹³

The National AIDS Control Program has estimated that HIV prevalence is 14% in the 15-49 age group.¹⁴ Rates of HIV infection are about 32% in Blantyre and 22% in Lilongwe, the country's two largest cities. Rural rates had risen to 13% in 1994, with prevalence among surveillance sites (ante-natal clinics) ranging from 3% to 28%. HIV surveillance data from rural and urban sites suggests that HIV infection may be reaching its peak. If so, AIDS mortality can be expected to increase for perhaps five to seven years before it peaks.¹⁵

Malawi was one of the first countries to establish a policy concerning orphans in response to HIV/AIDS. "Policy Guidelines for the Care of Orphans in Malawi" define an orphan as a child under age 18, one or both of whose parents are dead. Estimates of the number of children orphaned by AIDS, however, have generally been made only for maternal orphans. The National AIDS Control Program has estimated that the number of children who will lose their mother to AIDS will rise from 140,000 in 1995 to over 300,000 by the year 2000. A researcher commissioned by USAID/Malawi estimated that the number of maternal orphans due to AIDS would increase from 121,000 in 1995 to 689,000 by 2000.¹⁶

However, action to benefit orphans in Malawi should not be limited to those whose parents have died of AIDS. To do so would not only be unfair and extremely difficult in practice, it would also stigmatize the intended beneficiaries. When considering needs, it is therefore necessary to consider orphans from all causes. The economic impact of the growing number of children being orphaned by HIV/AIDS is that they significantly increase the number of children extended families are trying to support, further stressing the coping capacities of families, most of which are already extremely poor. Based on information from other countries similarly affected by HIV/AIDS, it would be reasonable to estimate that 10-15% of the country's five million children

have lost one or both parents. Malawi may have 500,000-750,000 orphans from all causes.¹⁷ Even if HIV prevalence rates were to peak at their current levels, the number of orphans in Malawi can be expected to increase very substantially for perhaps another five to seven years.

The problems emerging in Malawi among children and families affected by HIV/AIDS are similar to those seen elsewhere in Sub-Saharan Africa. The illness of a parent, often the father, reduces household labor capacity and income. Available resources and time of other members are redirected to caring for the person who is ill, increasing economic stress in already-poor households. Reduced economic capacity may mean food insecurity and difficulty paying for school expenses, basic material items, or medicines. Some families are so poor that inability to afford soap for children to bathe and wash their clothes has been barrier to their participation in Malawi's free primary education.

By itself and in combination with these economic problems, AIDS morbidity and mortality cause great psychosocial distress for those who are ill and their spouses and children. Cultural taboos about discussing an impending death often prevent acknowledgment of or response to this distress. The death of the father sometimes leads to a scramble by his relatives to claim his property under traditional law, leaving the widow and orphans in even worse economic circumstances. Often an infant, infected perinatally, falls ill indicating that the mother is also infected.

The economic stress is even more severe in a single-parent household with the parent ill. The extended family is the mostly likely source of any assistance with expenses or labor. With the mother's death, orphaned siblings are divided among other households within the extended family, sometimes going to live with a grandparent or, in rare cases, staying in the home without adult care.

In April 1996 the National Task Force on Orphans issued the "National Orphans Care Programme: 1996-1998." Apart from the attention that has been given to the needs of orphans, however, the HIV/AIDS epidemic in Malawi is still being addressed primarily as a health issue, not as a development issue. Little attention appears to have been given to the current or potential impacts on agriculture, for example.

A striking aspect of the country's response to its HIV/AIDS epidemic has been the lack of testing and counseling services. It appears that patients often are not told that they have AIDS, preventing them from coming to terms with the reality of having a terminal illness and from talking with their children, making plans for their care, or making a will to protect the inheritance rights of dependents.

BACKGROUND

The Displaced Children and Orphans Fund (DCOF) was established in 1989 by an act of the United States Congress and is administered by the Office of Health and Nutrition of the United States Agency for International Development (USAID). DCOF is supported by the Displaced Children and Orphans Fund and War Victims Fund Project of TvT Associates. DCOF has evolved into a program that focuses on issues of loss and displacement among three groups of children in the developing world: unaccompanied children affected by armed conflict, street children, and children orphaned by HIV/AIDS.

In October 1994 the Malawi Field Office of Save the Children Federation, Inc. of the United States (SC-US) submitted an unsolicited proposal to DCOF requesting funding to support children, families, and communities affected by HIV/AIDS in Malawi. The proposed program was called Community-based Options for Protection and Empowerment (COPE). Based on comments by DCOF and USAID/Malawi, SC-US subsequently revised the proposal and developed a logical framework (logframe) to measure its impacts. In August 1995 USAID committed \$538,000 of DCOF funds to SC-US for COPE through grant number 612-0249-G-00-5004-00. The period established for the grant was July 15, 1995 - July 15, 1997.

VISIT BY A DCOF TEAM

A team selected by DCOF visited the country October 6-18, 1996, to review COPE in collaboration with SC-US. The team consisted of Jill Donahue, small business consultant, and John Williamson, technical advisor to DCOF and team leader. The visit was planned as a collaborative review of COPE with its staff rather than a formal midterm evaluation. The team made a particular effort to understand the program in the context of the impacts of HIV/AIDS on children and families in Malawi generally, with a view toward identifying activities that might be taken to scale in Malawi or elsewhere. The COPE program was 15 months into its 24-month grant period at the time of the team's visit. COPE staff were preparing to phase out of the geographic area where the program had first been implemented and initiate activities in a new area. The review provided them an opportunity to reflect on the approaches and activities they had carried out and consider adjustments they might make in the new area. The team's scope of work is included as Appendix 1 and their itinerary as Appendix 2.

THE COPE PROGRAM

SC-US developed COPE as a multisectoral set of interventions to address the broad range of problems emerging among children and families affected by HIV/AIDS. The goal of the program is to "Improve the immediate conditions and long-term prospects for the care and healthy development of children affected by AIDS in three communities in Mangochi District (Mangochi Boma, Namwera, Monkey Bay), promoting sound policy development and implementation, alongside viable program interventions that can be adapted at the national level."

Located at the southern end of Lake Malawi, Mangochi is the third-largest of Malawi's 24 districts and has an estimated population of 609,000.¹⁸ Residents are primarily Yao, and 80% are Muslims. Mangochi Boma, the district's largest town, is located on the Shire River, which a short distance to the south widens into Lake Malombe. To the east the district borders on Mozambique. During that country's civil war, tens of thousands of refugees lived in Namwera and received international assistance. Some of the approaches that SC-US is using in COPE were developed for responding to the psychosocial needs of unaccompanied and traumatized refugee children.

Farming is the predominant occupation in the district. Fishing is common around the lakes, but the methods used have seriously depleted the primary variety of commercial fish. Trade and tourism are also part of the local economy. Mangochi's literacy rate is one of the lowest in the country.

In October 1994 SC-US began a preliminary field assessment in peri-urban villages in the Mangochi town area to provide a basis for developing the program and, with funding from UNICEF, initiated a pilot phase of the program. USAID subsequently provided the grant of \$538,000 for COPE for the period July 15, 1995 - July 15, 1997. Additional funding for the Life Skills component of the program was provided by UNDP. The agreement for these funds, which are to be used during calendar year 1996, was signed in May 1996.

The COPE logical framework (logframe) is based on the objectives specified in the proposal to USAID. It specifies indicators, means of verification, and important assumptions. Progress against specific objectives is reviewed below.

COPE is making a serious effort to measure its impacts through the development of an elaborate management information system. At the time of the team's visit, staff members were using 28 different forms to identify household conditions, monitor needs at the household level, report on activities, implement various components of the program, and measure the outputs. COPE staff should assess the utility of the information collected in relation to the staff time required to complete the forms and process the data and collect only what they need to know. Starting with

the current, elaborate system was an appropriate initial step, but now it needs to be simplified with a more cost-effective approach.

The proposal funded by USAID called for COPE to be implemented in three areas within Mangochi District: the Mangochi town area (where the program was initiated), Namwera, and Monkey Bay. By August 1996, however, SC-US had decided that it would not be feasible to implement the program in all three areas within the two-year time frame and decided not to initiate the Monkey Bay component. Even with this reduction in geographic scope, COPE appears to be essentially on track for achieving the numerical targets for most of the key objectives. The program's main activities are seen positively by the overwhelming majority of the community members and leaders, government personnel, and NGO staff with whom the team members spoke. The program is making good progress in achieving what it set out to do, and COPE staff are dedicated and highly motivated.

PUTTING COPE IN CONTEXT

More is at stake, however, than achieving the targets specified in the logframe. COPE is a pilot effort to develop and test a set of interventions that can be taken to scale. As it stands at month 15 of its 24-month funding period, significant adjustments are needed to bring down costs. The SC-US staff, preparing to initiate COPE in Namwera, face the challenge of developing a set of sustainable interventions that can make a meaningful impact at a significantly lower per capita cost.

In the nine villages in the Mangochi town area where COPE has been implemented, there are 4,456 households. Of these, 704 (16%) were identified by COPE staff as primary-target households using the following categories:

- ⌄ Family keeping children who have lost one or both parents
- ⌄ Grandparent or elderly woman by herself who is keeping children who have lost one or both parents
- ⌄ Adolescent taking care of children
- ⌄ Single woman or widow alone keeping children
- ⌄ Very sick or terminally ill adult or person who is sick frequently.

There are 4,154 members in the primary target households, 2,409 (58%) of whom are children. The total population of the nine villages where COPE was being implemented in the Mangochi

town area was estimated to be 18,000-26,000.

At the request of the team, COPE staff began the task of trying to estimate the cost per beneficiary of each of the key interventions of the program. This task proved to be much more difficult than anticipated, however. At this writing, three weeks after the conclusion of the team's visit, COPE staff are still engaged in the laborious task of trying to extract the necessary information from expense ledgers. Hopefully, the process will yield information that they can use to compare the relative costs of different interventions, with a view toward developing a model that could be implemented at scale. The process should also enable them to design a system for tracking inputs and effort for future projects, so that it will be easier to calculate costs per beneficiary for a specific intervention.

In the absence of such figures, the team made the following observations:

C At month 15 with expenditures on or somewhat ahead of schedule, COPE had expended approximately \$336,250. Assuming that half of the members of the primary-target families have benefited significantly from COPE, the cost per beneficiary would be \$162. Assuming that every primary-target household has benefited significantly from COPE, the cost per household would be \$478.

C For the COPE model, as it has been implemented in the Mangochi town area, to reach even 10% of the estimated 500,000-750,000 orphans in the country would cost \$8-12 million. However, funding at this level is not likely to be available, especially since much of Sub-Saharan Africa is facing similar problems and competing for donor funds. Moreover, the number of orphans can be expected to continue increasing for several years.

It is important to keep this larger context in mind in considering the interventions that COPE has implemented. These are discussed in the following sections.

ECONOMIC INTERVENTIONS

COPE's initial community assessments revealed that the weakening economic situation of most households was seriously undermining families' ability to deal with the consequences of HIV/AIDS. When parents either become caregivers for sick family members or fall ill themselves, they are less able to contribute their labor toward household needs. Families that are already struggling to make ends meet may be pushed further into poverty when they take in children whose parents have died. During such times of severe economic stress, households are forced to neglect farming and search for less labor-intensive ways of generating income (e.g., petty trading, food preparation and sales, beer brewing). Income is used to buy whatever food household members cannot produce themselves as well as basic necessities such as clothing and soap. COPE staff realized that unless they could help increase household income, any other

interventions would be ineffectual. Consequently, a microenterprise credit scheme using village bank methodology (Group Guaranteed Lending and Savings) and promotion of income-generating activities (dimba gardening) were built into COPE's design.

A Need for Appropriate Household Targeting and Clear Objectives

The team discussed with COPE staff the importance of distinguishing among the different types of households identified as primary targets because their compositions and vulnerabilities differ, and their capacities to make use of the various COPE interventions vary, as well as change over time. The potential of households to participate in and benefit from economic and other interventions depends to a large extent on how members' time is being used and whether they can free time for another activity. COPE staff, therefore, need to understand how members of different types of households are using their time. Interventions that help reduce current labor demands could free time for other productive activities. This might involve, for example, helping a village to organize a community-based child care center (see proposed UNICEF/government initiative, page [31](#)) or helping artisans produce fuel-efficient stoves to reduce time spent collecting firewood.¹⁹

Table 1 suggests some of the profiles that exist among households affected by HIV/AIDS.

Table 1. Household Profiles and Their level of Economic Stress

Household Characteristics	Economic Stress
Two parents, one of whom is periodically ill	moderate/high
Household headed by single surviving parent	moderate/high
Single head of household who is periodically ill	severe
Two-parent household caring for children whose parents have died	moderate
Household headed by a grandparent	high
Adolescent-headed household	high

Households differ not only in their composition and economic vulnerability, but also in their ability to engage in income generating activities. Development organizations concerned with strengthening the economic resources of poor households have learned that varying levels of economic activity exist and that it is worthwhile to distinguish among them when designing projects. Experience has shown that the most effective development projects match assistance to the needs of a particular level of economic activity. (See table 2).

COPE's primary-target households are the poorest in their communities. They operate largely in the survival economy, struggling to provide the most basic household requirements. Business at this level is most concerned with bringing cash into the household. Profits, if any, cannot be spared for reinvesting in the business because all household resources must be focused on basic survival—particularly on acquiring enough food. These survival businesses will not be a source of job creation nor can they be expected to be an “engine of growth” for macro economic development.

Table 2. Framework of Business Characteristics

Level	Characteristics	Type of Assistance
Survival Economy	Owner engages in activity for survival purposes to generate cash for household consumption. Owner typically relies on multiple activities that vary seasonally. Growth of activity (requiring reinvestment of profits) is not owner's primary objective. Most activities have no business development potential but are effective for raising income for household consumption.	Assistance is most effective when it matches the owner's objectives of increasing sales (cash income). This is most immediately accomplished by improving the owner's access to market information; growing, unsaturated markets; and more economical sources of raw materials. Credit will be helpful if it increases profit margins by enabling the owner to buy goods or raw materials in bulk at cheaper per-item costs. Credit can also enable the owner to increase sales volume.
Micro-enterprise	Owner's primary objective may still be to generate cash but he/she has chosen self-employment as the primary source of income. Owner still uses most business profits for household consumption but may occasionally reinvest in the business. Household members may be engaged to assist in the business.	May need assistance in improving production or quality of product or service. Linkages to market, market information, and sources of raw materials may need strengthening. Training in costing/pricing and cash management may be useful. Credit is still primarily for working capital.
Small Enterprise	Owner has chosen business as the primary source of income. Growth is an important objective. Owner reinvests all profits in business and employs one or more persons outside his/her household.	Owner can make use of training to improve business operations (accounting, pricing/costing, marketing, business plan, etc.). Credit may be needed for fixed capital investments.

There nevertheless is evidence in Malawi that improving access to credit has a positive effect on food security for the poorest of the poor.²⁰ This finding is further supported by the experience of other countries that are implementing microenterprise credit—or more specifically, poverty-lending—programs that target people in the survival economy.²¹ A literature review and analysis

conducted by Freedom from Hunger concludes that:

poverty lending is unlikely to produce major economic gains for poor households. However, in relative terms, these modest gains seem likely to make very important contributions to household survival, such as income smoothing and insurance against emergencies. And these are precisely the types of livelihood strategies that, if strengthened, are most closely associated with increased household food security and nutritional status.²²

Strengthening income-generating businesses also makes it more likely that relatively less poor households will be able to assist the most vulnerable in their community. A study of the effects of drought on the rural food economy in Malawi's Mchinji and Salima Districts indicates that in times of severe economic stress, the poorest families in a community can usually obtain some relief from their better-off neighbors. However, as the drought continues and the resources of better-off families are reduced, sources of assistance also decline. This erosion of community wealth leaves the poorest households with almost nowhere to turn.²³

It is important that COPE reorient and sharpen the focus of its economic interventions. The program should not expect to increase significantly all the economic resources of primary-target households, to create employment, or to stimulate business development. However, the income-generating strategies that COPE can strengthen through poverty lending will contribute to food security and will support households that can in turn act as a community safety net for their more vulnerable neighbors. This type of poverty mitigation is a legitimate aim when households are faced with the prospect of destitution—as opposed to being simply poor.

Group-Guaranteed Lending and Savings and Dimba Gardens

COPE's economic interventions were designed to make sustainable improvements in the economic resources available to primary-target households. COPE staff also expect that economic interventions will improve group cohesion and community support. The assumption is that by participating in COPE's interventions, families' economic resources will be enhanced through an increase in income. It is further assumed that families will use these resources to provide better, or at least adequate, care for children. Women-headed households are particular targets for COPE activities not only because such households usually experience the most severe distress, but also because women are the most likely to direct resources to fulfilling children's needs and supplying food for the household.

SC-US headquarters in the United States has developed a village banking, or microenterprise credit, model for its field offices, Group-Guaranteed Lending and Savings (GGLS).²⁴ The GGLS component is especially well suited to the COPE program's women-centered approach since it is

designed—as are most microcredit programs—to remove the usual barriers women face in gaining access to credit. Microcredit programs have “packaged” their services to attract women clients because worldwide experience has shown that they are creditworthy clients who generally achieve excellent repayment rates. COPE is using the GGLS model to assist women in the poorest socioeconomic strata of their communities who engage in survival-level income-generating activities.²⁵

In the GGLS scheme, poor women are provided with small loans to start or strengthen small enterprises. Women in a COPE community are invited to organize themselves into groups of 15-20 members. GGLS staff screen groups identify and disqualify women who: 1) currently have outstanding loans; 2) are unable to manage a business because of poor health, advanced age or lack of business interest and motivation; or 3) are relatively well-off. Each group is required to attend four training sessions conducted over as many weeks. Following the training, one loan is extended to each group, which on-lends the amount requested by each individual (loans average K1,000/\$67). The size of the loans is kept small to attract the poorest households, who typically engage in short-term, rapid-turnover trading activities. These are the activities most likely to benefit significantly from infusions of additional working capital. Each group is collectively liable for the loan, which must be fully repaid before additional credit is released. Members are also required to make deposits in a group savings account. Group savings are intended for use as a capital fund upon which members can draw for future loans. In extreme cases, group savings can also be used to cover defaults. GGLS staff collects repayments during weekly group meetings for deposit in the SC-US commercial bank account. The group collects members' savings for deposit in a separate account. The weekly group meetings with COPE staff provide a forum to discuss business improvements and to resolve individual repayment problems.

COPE is also promoting other income-generating activities (IGAs). Many of the caregivers in COPE's primary-target families are adolescents, grandparents, or seriously ill individuals. Others are perhaps less “business oriented” than those who participate in the GGLS scheme. COPE staff have sought to identify alternative IGA activities that could provide sustainable increases in income to these vulnerable households. Only wetland (dimba) gardens were found to have good promise. This activity is limited to people with access to land along the banks of the Shire River. Although several of the poorest members of COPE communities have had access to such land, they were unable to exploit it fully because of severe financial limitations. COPE provides selected households with one-time, in-kind support such as seeds, pesticide, and tools. Participants are expected to supply the inputs for subsequent years. An agricultural advisor and field staff provide training and advice on production and marketing. Practical training sessions take place in demonstration gardens hosted by program beneficiaries chosen by their communities as trustworthy and of high moral character.

Progress Toward Objectives

As of the end of September 1996, 343 individuals had participated in GGLS and other IGAs; the target is 500. It was also projected that out of the 500 participants, 200 primary-target households would increase their economic resources. Development of a general economic resource measure (GERM) instrument to measure progress against this objective is being completed and will be implemented in the near future. Of the 343 participants, 292 are GGLS recipients (200 of whom are from COPE primary-target households) and 51 (all from primary-target households) participate in the dimba garden component.

It appears that the economic interventions will reach the targeted number of beneficiaries. However, it is not yet certain whether the interventions have strengthened the economic resources of the primary-target households.

Impacts

COPE's economic interventions are reaching 36% of the targeted households. Sixty-eight percent of GGLS members are in target households, a percentage that surpasses that projected in COPE's annual work plan.

During interviews, GGLS members and dimba gardeners said they were able to buy higher-quality food as a result of participating in these activities. All interviewees said that they had always been able to supply at least the maize portion of their meal; now they are able to improve the quality of the "relish" that goes with it—adding protein such as meat, fish, and chicken.²⁶ In addition, GGLS women said they can now afford to provide soap, salt, sugar, clothing, and school supplies for the children in their households. At least two women in the GGLS program said they are able to employ casual laborers to tend their gardens or help market their products, allowing them to spend more time at home with their children and to concentrate on improving their businesses. Field staff have noted that families involved in the dimba gardens are teaching their children gardening skills that could enable the children to secure a livelihood in the future.

However, there were indications that COPE's economic interventions are not reaching the most vulnerable households (see table 1). One GGLS group spoke of two members who dropped out between loan cycles; one who was caring for her sick child and the other who said only that she "needed a break." They also spoke of a current member whose husband was critically ill and who was herself suffering from shingles; the group recognizes that she will not be able to continue operating her business and repay her loan. In addition, two of five GGLS members who were interviewed individually had to seriously curtail their business activities to care for terminally ill family members. In fact, it appears that the strain on a household, particularly when headed by a woman or a grandparent, is such that many cannot continue to work in their gardens and farms. Even relatively less labor-intensive income generating activities are

neglected.

Given the demands that HIV/AIDS places on a household's available labor, it is unlikely that any economic intervention will directly alleviate the distress experienced by the most vulnerable households. Yet the GGLS group that told of the woman suffering from shingles asked for advice on how they might find assistance for her and her family. Even though this desire to help was motivated by the group's collective liability for the GGLS loan, it none the less indicates that COPE's expectation of improved group cohesion through its economic interventions is well placed. It is also consistent with the view that strengthening the economic capacity of less vulnerable households will enable them to help the more vulnerable ones.²⁷ The goal of mobilizing support and resources to create a sustainable, community-based safety net thus appears to be realistic.

Coordination and Collaboration

To ensure the long-term sustainability of the GGLS program, COPE staff were investigating the possibility of "graduating" GGLS women to the Commercial Bank of Malawi (CBM) through a credit guarantee fund (CGF). With such an arrangement, SC-US would deposit funds for the CGF in an interest-bearing account. In the case of default, the bank would cover 20%, SC-US would cover 70%, and the remaining 10% would come from GGLS groups' collective savings. CBM would provide routine administration of the funds, and all other administrative and monitoring responsibilities would fall to GGLS staff. This collaboration was seen as a way to facilitate an ongoing relationship between the women and a formal financial institution. Eventually, it was hoped, CBM would lend directly to the women, eliminating the need for GGLS. However, during the team's interview with the CBM's credit analyst, it became clear that it would be too expensive for the bank to administer and monitor small loans to groups. CBM will not be able to change its standard operating procedures to fit the needs of COPE's primary-target households.

The German development agency (GTZ), through the Ministry of Women and Children Affairs, Community Development and Social Welfare (MOWCACDSW), has been involved in such an arrangement with CBM for the last five years. In that time, only a handful of women are ready to "graduate" to direct lending from the bank. According to the CBM credit analyst, when the bank decides to loan directly to women in this type of program, it tends to rely on the track record established through good management of individual accounts. FINCA/Malawi, a village banking program similar to GGLS, also hopes to "graduate" some of its clients to the commercial bank. To that end, women are encouraged to open individual accounts in addition to those that FINCA opens for group savings and repayments. By so doing individual women can establish the track record the bank values without the benefit of a guarantee fund.

The team interviewed several microcredit NGOs to gain insight on current issues. One praised

COPE staff for seeking to coordinate their credit activities with other development organizations engaged in similar efforts. Figure 1 is a general summary of how several credit programs compare in terms of where they target their assistance. All (except the savings and credit cooperatives) have lending principles and credit-delivery mechanisms particular to microenterprise credit programs:

- C Credit is extended to self-selected groups and on-lent to individual members.
- C Group liability for loan repayment acts as collateral and serves as social pressure for repayment.
- C Small, short-term loans are to be used primarily for working capital.
- C Simple application procedures eliminate the need for complex business plans or accounting records.
- C Savings mobilization through required member deposits is emphasized.
- C Interest rates at or above market rate are charged to recover costs.

Figure 1. Comparison of Credit Programs and Their Target Groups

	<i>Credit Program</i>				
	GGLS	MFRC/ GTZ* & FINCA	WWB DEMAT	NABW	SACCOs**
T A R G E T	IGA				
		IGA			
	ME				
		ME	ME		
				ME	
		SE			
			SE	SE	SE

Note: This chart is intended for purposes of a general comparison, not as a formal analysis of each program.

Shaded areas indicate the portion of a particular category of economic activity covered by a given program.

* GTZ's (German technical assistance) program, PMERW, recently merged with MRFC.

** SACCOs also provide credit to medium- size, and sometimes large, businesses.

Key to Acronyms:

DEMATT = Development of Malawi Trust

IGA= Income-generating activity of survival economy

ME= Microenterprise

MRFC = Malawi Rural Finance Company

NABW = National Association of Business Women

PMERW = Promotion of Microenterprises for Rural Women

SACCOs = Savings and credit cooperatives (credit union)

SE= Small enterprise

WWB = Women's World Banking

As figure 1 illustrates, each program targets slightly different levels of economic activity. GGLS appears to be reaching the deepest into the survival economy. Only the SACCOs (Savings and credit cooperatives) are a formal financial institution. WWB is the only NGO that intends to become a bonafide financial lending institution.

Alternative Approaches

Collection of repayments by GGLS. The cardinal principles of successful poverty lending programs are belief in the ability of very poor people to contribute to their own development and the need to capitalize on social and peer pressure to hold people accountable for externally supplied loan funds. Development workers must resist the temptation to do for their program's beneficiaries what the beneficiaries can, and should, do for themselves. GGLS staff is currently depositing repayments for their women's groups because both COPE staff and the participants were concerned about holding large amounts of money.²⁸ Nevertheless, COPE staff must trust the groups to make their own repayments. The women will never trust themselves or take full responsibility for the loans until they realize the true weight of their accountability. To facilitate this approach, GGLS might try to form smaller solidarity groups of five to seven women. First, a smaller group will find it easier to establish trust and accountability. Second, the amount collected each week will also be smaller, which should make the women more comfortable with the risk of holding deposits overnight. To contain program costs, however, the smaller groups should be instructed to converge in a mutually agreed upon location so that COPE staff can efficiently verify deposits and hold weekly meetings. After the first loan cycle, the women may have enough confidence and trust in the system to merge the smaller groups. Finally, GGLS staff should consider setting up repayment and savings accounts at the more conveniently located post office instead of a commercial bank. The recent reorganization of the post office system separated its savings function from its mail-handling operations and consequently improved services. WWB and FINCA both use the post office with satisfactory results. WWB even invites postal managers to training sessions for new lending groups who will set up accounts at the post office.

Screening of GGLS participants. More households than specified in the work plan participate in lending groups, due in part to the expensive, time-consuming process of screening individual members. Microcredit programs ordinarily rely on the way in which their credit products and services are packaged to predetermine the clientele that will be attracted to them. Similarly, the responsibility of ensuring that individuals fit membership criteria is placed on the group itself. The COPE screening process, by contrast, somewhat artificially engineers group composition by taking on functions typically handled through credit packaging and group accountability. This may undermine the delicate mix of peer pressure and group accountability on which the success

of lending programs must be built. GGLS staff should experiment with their screening process using it for only some groups. The composition of screened groups can be compared with that of non screened groups. If group composition is satisfactory in the non screened groups, it would be an indication that careful packaging of credit services and group responsibility for adhering to membership criteria will adequately ensure that GGLS is attracting the clients COPE is targeting. Also, COPE should eliminate the individual loan application forms it uses to help reduce implementation costs.

Training (pre-loan and weekly meetings). At pre-loan sessions GGLS staff should stress the rules and responsibilities of the lending and savings program rather than basic business skills. Concepts that appear to be particularly difficult to grasp or accept should be covered thoroughly. For example, the concept behind making weekly payments could be demonstrated through skits or role plays. The rotating savings and credit association (ROSCA) game developed during the team's visit could be used to illustrate the idea of rotating savings and credit and the importance of the group guarantee.

GGLS staff can use the last weekly session in a loan cycle to find out what each woman believes has contributed to the success of her business. These successes could be used to illustrate business concepts at weekly sessions for the next loan cycle. For example, a GGLS participant who sells cloth at the Mangochi market attributes her success to good customer relations and ensuring that she has made a profit before she spends money. She could be invited to explain at her own group's weekly session what she does to maintain good customer relations and how she determines her profits. If other groups are willing to cover her transportation costs, she could be invited to discuss these topics at one of their weekly sessions. GGLS staff could obtain more ideas through a field visit to WWB, which developed a similar strategy called the Enterprise and Learning Network.

Community-based organizations. COPE staff should galvanize, or catalyze the formation of, community-based organizations (CBOs). CBOs could create a sustainable safety net that would link the most vulnerable households of COPE's primary targets with needed assistance. Economic interventions cannot be expected to perform this function. Access to credit helps many of the target households and, as noted earlier, dimba gardens may be a good idea for individuals who cannot participate in the GGLS scheme or are not "business oriented." But since households affected by HIV/AIDS are extremely sensitive to increased labor demands, the effort required to run a business or tend a garden may be beyond their capabilities.

The roots of such organizations could be found among women's associations, mothers clubs, drama groups, or religious groups that visit households in severe distress to offer relief. To develop sustainable methods of fund raising, COPE could assist the CBOs to organize raffles,

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contests, or entertainment events (e.g., drama performances, dances) which local community members would willingly pay to attend. The attendance fees could conceivably provide a good portion of the CBO's operating budget.

HEALTH ACTIVITIES

Home-based Care

COPE's primary health intervention has been to train caregivers and community volunteers in home-based care. Once doctors at the Mangochi District Hospital, have determined that an AIDS patient or otherwise terminally ill person will not benefit significantly from continuing hospital care, the patient is told that there is nothing more that can be done and then sent home without a diagnosis. Only rarely is counseling and testing done for HIV.

COPE staff report that most of the terminally ill patients with whom they come in contact prefer to be cared for at home instead of the hospital. To enable caregivers to care more effectively for patients at home, COPE has developed a simple curriculum for home-based care, with components on hygiene and sanitation, nutrition, and physical care. The training includes instruction in how to treat common ailments and enable patients to live with as much comfort and dignity as possible. It also encourages caregivers to build their own support systems of family members and neighbors to help with labor, food, and other needs. COPE's Health Coordinator was ill during most of the time the team was in Mangochi, limiting the information available about health activities.

COPE initially identified households with a seriously ill member through its baseline survey. Other households that could benefit from training were identified through contacts with village headmen and headwomen; referrals from community volunteers, caregiver support groups, and Government of Malawi (GOM) health surveillance assistants; as well as self referrals. COPE offers training to caregivers, and when enough are identified, staff organize a three-day group training session. Staff make regular visits to the homes of trainees to assess the quality of care (using a form COPE has developed) and make suggestions on how to improve it. COPE has also trained community volunteers, religious leaders, and health workers at the hospital, clinic, and community outreach levels in home-based care. Staff have also trained volunteers as trainers and built village-level networks of caregivers and trained volunteers, through which participants support each other and share resources information and skills.

In addition to caregivers, COPE trained a group of Muslim sheikhs and Catholic priests from the district. The intention was to enable them to help patients and instruct caregivers when they visit homes and to facilitate the formation and strengthening of community support systems. There had not been any follow-up to assess the effectiveness of this training.

Leaders and residents in target villages indicated that the skills gained through this training were highly valued. One village headman said that those who had been trained were perceived as having valuable expertise and were sought out by others in the community for advice on health problems. During a home visit, a young woman living with AIDS explained that she was much

more comfortable after her mother participated in the training because her mother learned how to bathe her and what she could eat.

Training for home-based care has only addressed physical care issues, but it could also help families deal with psychosocial distress and inheritance issues. Households faced with serious or terminal illness experience psychosocial distress. Also, after a father dies, widows and orphans may lose some or all of the household's property if claimed by the man's relatives under traditional law. However, to address these issues through its training COPE will have to deal with a strongly rooted cultural reluctance to discuss an impending death. This reluctance is reinforced by stigma associated with HIV/AIDS. If a lay person were to talk about an individual's illness as being terminal, the remarks could be interpreted as witchcraft and an attempt to cause the sick person's death. The team learned that although family members and neighbors generally recognize the signs of AIDS-related illness, they deny that the person has AIDS and is going to die. Denial prevents the patient from coming to terms with his or her impending death and from making preparations to protect his or her children's inheritance.

While the process of accepting the reality of having a terminal illness is painful, those who go through it generally achieve greater peace of mind. Children of school age often recognize when a parent has the symptoms of AIDS-related illness. If the parent with AIDS and other adults in the household will not admit that the parent's condition is terminal, however, these children suffer severe stress because they cannot express their fears or talk with anyone about what is going to happen.

Hospital staff have not made referrals to COPE, apparently because patients are not usually given a specific diagnosis. This means a patient returns home and stays for some time before COPE can identify and train a caregiver. The situation in Mangochi would be improved if hospital staff counseled patients and recommended testing for HIV when clinical symptoms indicate the possibility of infection. Although the reason cited by the District Health Officer was that sufficient staff are not trained in AIDS counseling, others familiar with the situation said they believed the reluctance was primarily cultural.

Health Referrals

During COPE's initial assessment in November 1994 many community members expressed concern about poor health and high mortality among children under five years of age. COPE is seeking to improve the health and nutrition of this age group by encouraging community members to use existing health services and making referrals to them. Of particular concern are children who are injured, under weight, not fully immunized, or do not have a health card (indicating that their health and growth are being monitored). COPE staff follow-up to check compliance with referrals. These efforts are similar to those that government health workers are

or should be making.

Progress Toward Objectives

As of the end of September 1996, 201 primary target household caregivers had been trained in home-based care; the target is 500. Unless a different approach is taken, it is not likely that this target will be reached by the end of the DCOF grant.

In addition, 257 other people (e.g., religious leaders, community volunteers) had been trained in home-based care, and 15 home-based care trainers had been trained. No targets were established for these activities.

Care for seriously or chronically ill patients had been measurably improved in 95 primary- target households; the target for this indicator is 100.

Thirty-nine primary target children had been referred to under-five clinics and 45 to the hospital. No target was established for this activity.

Impacts

The training in home-based care provided by COPE appears to be having a very positive impact. Patients in households in which someone has been trained are able to live more comfortably and with greater dignity, which should have positive, indirect benefits for their children. The training also has had secondary benefits where participants have passed on what they have learned to other community members. The caregiver support groups COPE has helped organize have increased the sustainability of the impacts of training.

Coordination and Collaboration

COPE has coordinated with government health personnel from the district hospital to the community level, and has trained religious leaders in home-based care. Closer collaboration with hospital personnel appears to be needed, however, to establish a workable system for referring discharged patients and their caregivers to COPE and/or to initiate training in home-based care while patients are hospitalized.

Alternative Approaches

Psychosocial and Inheritance Issues. As discussed earlier, COPE's home-based care component could be improved by broadening its scope to address the psychosocial distress of patients and their children. It could also be used to inform households about inheritance issues.

Referrals by Hospital Staff. The efficiency of the current system would be improved if hospital staff would make referrals to COPE at or before the time of discharge, as noted earlier. The District Health Officer agreed that, without making any specific diagnosis, it should be possible for hospital staff to ask patients and their accompanying family members who are returning to an area where COPE is working if they would like to be contacted about training for home-based care. With their consent, hospital staff could then make a referral to COPE.

Training at the District Hospital. A more fundamental change seems preferable, however. Hospital patients are typically accompanied throughout their stay by a family member who assists with their care. The District Health Officer agreed that it should be possible for COPE to carry out or at least initiate training for care providers before a patient is discharged. He indicated that at any given time there would be about 10 caregivers who would benefit from such training--enough trainees for a class. Training a care giver before a patient is discharged would eliminate the current lag between return home and training. Methods of care could be demonstrated on patients. The impact of training for home-based care would be district-wide, enabling COPE to reach more people more cost effectively.

COPE staff identified an advantage to the current approach, however. By training together people who are living the same area, informal support networks have developed among caregivers and community volunteers. Also, with the approach proposed by the team, patients not entering the hospital would be missed. By carrying out follow-up training or organizing meetings for care providers at the village level, COPE could avoid these potential drawbacks.

Health Referrals. The under-five referral component of COPE is responding to genuine needs, but it overlaps with efforts of government health outreach workers. Also, any direct service role provided by COPE staff will end when the program moves on or ends. In view of the need to reduce program costs and develop sustainable approaches, SC-US should focus on sensitizing community leaders, government health workers, caregivers, and volunteers to the importance of ensuring that children under five years of age benefit from available primary health care services and eliminate COPE staff's direct referral and monitoring roles.

ACTIVITIES TO PROMOTE CHILDREN'S PSYCHOSOCIAL

WELL-BEING

COPE has secured donations on a matching-fund basis for the secondary school expenses of adolescents in primary-target families. Under the banner of “life skills,” the program also supports structured recreation, drama groups, and skills training linked with other non-formal education.

Assistance with Secondary School Fees

While fees for primary education were eliminated by the new government in 1994, secondary school fees are often beyond the reach of very poor families. Although secondary school graduates are not certain of obtaining a job in the short-term, this level of education is required for many types of employment beyond the subsistence level. COPE has been successful in persuading organizations, companies, and individuals to contribute on a matching-fund basis to the secondary school fees of students from primary-target households. SC-US has sought contributions in the country’s three largest cities as well as locally. The largest contribution to date was by the Islamic Zakaat Fund, which contributed K25,000 (\$1,667). Although these funds can be used only for Islamic students, the overwhelming majority of residents in the target villages are Muslims. Other contributions that COPE has secured can be used for non-Muslim students.

One concern, however, is that the 50% match that COPE has provided may jeopardize the sustainability of the initiative. Another is that it has been a labor-intensive process for COPE to secure timely invoices from and make payments to scattered individual schools as well as to obtain progress reports from headmasters for forwarding to scholarship contributors. Such problems might diminish if this activity became institutionalized and better known among secondary school personnel.

Structured Recreation

Among the activities intended to promote children’s psychosocial well-being, structured recreation involves the largest number of participants. Specific activities, including soccer, netball, traditional games, songs, dance, drawing, and drama, have been well received in the villages. Activities are open to all children in a community, but COPE field workers have made special efforts to involve children from primary-target families. At one of the recreation sessions the team visited, a field worker pointed out an animated soccer goalie who, she explained, was an orphan who had been staying at home feeling sad and lonely. The field worker said that she believed that the child’s participation in recreation was helping him recover.

Recreational activities provide a valuable emotional outlet for children living with the distress caused by the effects of AIDS on their families. Such activities can also help increase the social integration of children who are withdrawn and isolated. Play allows children who have suffered losses and hardships to express pent-up emotions and, by exercising their imaginations, to gain a greater sense of control in their lives.

The team discussed with COPE staff its concerns about the sustainability of the recreational activities, which appear to be dependent on the ongoing support and involvement of program staff and inputs. Although community members have been involved in clearing recreation fields and community youth have been recruited as volunteers to supervise as well as participate in recreational activities, the field workers seemed to play essential roles in ensuring that activities took place and that necessary resources were available.

Material inputs are another concern. At one meeting in a village, recreation volunteers asked SC-US to provide another soccer ball. The cost of a durable soccer ball in Mangochi can exceed \$60, which is well beyond the reach of the overwhelming majority of rural residents. With COPE ready to phase out of its involvement in Mangochi and shift to Namwera, the continuity of soccer, which has been very popular, is in doubt. Similarly, although children enjoyed drawing and coloring on donated paper that the SC-US secured from a business in Blantyre, it is not clear how this activity will be continued once COPE phases out.

Drama Groups

COPE has encouraged children and youth to form village-based drama groups that plan and perform skits and plays to sensitize and inform residents about problems among widows and orphans, respect for traditional values, the importance of school, AIDS prevention, civic education, and other topics. Although it is difficult to measure the impact of these groups, they have apparently been popular, especially the one from Misi Katema village. That group has charged admission for its performances at the local primary school and used one-third of the proceeds to buy bars of soap for and make small cash gifts to patients receiving home-based care. Another third has been retained by the group as a whole, and the balance was divided among its individual members.

The nine-member Misi Katema drama group was organized by a resident who had been a member of a well-known professional troupe. The group would like to secure a loan to finance their travels to places where they could draw larger crowds and charge a substantially higher admission fee. Three members of the group also volunteered to be trained in home-based care and to pass on the skills to others in the village.

Skills Training and Other Non-formal Education

This has been the slowest component of the COPE program to get off the ground. It follows a school-based skills training program that SC-US ran in 1995 with funding from UNDP. The slow start has been partly due to a protracted period of negotiation with UNDP about the content, scope, and goals of the activity. Funds were eventually granted for calendar year 1996, and the agreement was signed in May 1996. Implementation has also been delayed by the participatory process COPE staff have subsequently pursued. Their intention has been to enable community committees to develop proposals which COPE would then judge on merit. After pursuing this strategy for five months, however, only one very weak proposal was developed. With the UNDP grant due to expire, it seems that COPE will have to request a no-cost extension, initiate some activities quickly, or return the unspent funds.

With a view to initiating some skills training activity even before the UNDP funds were secured, SC-US hired an experienced teacher living in one of the target villages to teach knitting, sewing, crocheting, and cooking to a group of 24 adolescent girls. She also teaches about family life issues. Although the activity may help steer the young women away from risky behaviors and provide opportunities for positive social interaction, the skills being taught will have marginal economic value, at best.

Five boys in the target villages are completing training in motor vehicle mechanics and body repair under UNDP's 1995 grant to SC-US for in-school vocational training. Another 14 youth in the target villages participated in a two-week textile weaving course arranged by SC-US.

The continuation of life skills training will depend on additional UNDP funding. It may be possible for COPE to arrange a few apprenticeship positions, but the approach taken so far does not appear to be cost-effective or sustainable.

Progress Toward Objectives

Grants have been provided to 94 secondary school students; the target is 100.

Of the target of 3,000 children attending structured recreation activities, 2,268 children had participated during the period July-September 1996. Of these, 562 (25%) were from primary-target households; the target for this group is 1,000.

Forty-three of a targeted 50 adolescents have participated in vocational training.²⁹

Impacts

The most tangible benefit achieved by the program's psychosocial activities is that 94 students who probably would not have otherwise attended secondary school are doing so. A large number of children are taking part in recreational activities, and anecdotal reports suggest that children from target households have benefited from their participation.

As noted earlier, some patients in home-based care have received soap and small amounts of cash from a drama group. SC-US reports that drama activities draw large crowds and that older children have been increasingly involved in planning and staging plays. It seems likely that residents have benefited from or been mobilized by the information conveyed, but neither impact has been measured.

The long-term economic benefits to the girls who have learned to knit and sew are likely to range from slim to none. Although their participation may have other significant psychosocial benefits, these would be very hard to judge. The team is not in a position to assess the potential benefit of training in weaving or motor vehicle repair.

Coordination and Collaboration

The process of securing donations for secondary school fees has been highly collaborative. Paper used in structured recreation for drawing was donated by a company in Blantyre. UNDP provided funding for life skills activities.

Alternative Approaches

Secondary School Scholarships. Possibilities for increasing the sustainability of secondary school scholarships include finding a civic organization or national NGO to take on the program or maintaining it as an ongoing SC-US program in its own right.

Structured Recreation. The approach used in the villages in the Mangochi town area requires a hand-over of responsibility to the community, which views the recreational activities as a COPE effort. In Namwera, if activities are initiated by people in the community (who then would have a sense of responsibility and ownership toward them) it seems more likely that the activities will be sustained. Instead of directly organizing structured recreational activities, COPE staff could help community residents to understand the potential benefits of such activities for their children. If residents decided to initiate such activities, the role of COPE staff would be to support residents' efforts.

To sustain soccer, COPE might be able to arrange sponsorships by local businesses. For example, a business might agree to provide a soccer ball and a cup for a local tournament in

return for community recognition of its sponsorship. In Namwera, it would make sense to emphasize activities with less costly material inputs that would be easier for the community to sustain.

Skills Training. With only a few months remaining for the USAID grant, COPE could concentrate on arranging apprenticeships in skill areas likely to lead to employment for a few youth, rather than trying to mobilize communities to plan more elaborate life skills activities. COPE might also explore ways to initiate EDZI Toto (anti-AIDS) clubs among youth in the villages.

ADVOCACY AND TRAINING

Through advocacy and training, SC-US staff have sought to influence how other bodies respond to the needs and problems of children and families affected by HIV/AIDS. Through the participation of SC-US staff in the National Task Force on Orphans, COPE has played an active role in the development of the government's "Orphan Care Program: 1996-1998," which establishes a goal, objectives, strategies, and specific program activities for addressing the needs and problems of children orphaned by AIDS. COPE's advocacy of community-based approaches was a key counterweight to groups promoting institutional care and helped to shape the GOM's policy in this area. At an early stage, COPE staff worked to sensitize businessmen to needs and problems in the target communities, inform them about COPE's efforts to address these problems, and discuss how businesses could help by sponsoring activities or individual secondary school students. COPE was able to link seven vulnerable households with Caritas, a Catholic NGO, which provided them food and nutritional supplements for the younger children.

The original COPE proposal calls for a national conference to examine ways to support community efforts to aid HIV/AIDS-affected children and families. It is not clear, however, whether sufficient funding will be available for this effort. Such a conference would provide an important opportunity for information exchange and advocacy. Chapter three of *Children and Families Affected by HIV/AIDS: Guidelines for Action* suggests ways such a conference could be a vehicle to help influence leaders, organizations, and the public.

COPE has offered to train Ministry of Health staff in home-based care to enable them to train care givers. Fifty-two Muslim religious leaders and 42 Catholic seminarians were trained in home-based care in the hope they will pass on these skills. Training also sensitizes leaders to the needs of affected households. Similarly, informing members of parliament about COPE and soliciting their contributions to secondary school scholarships raises their awareness as well.

A COPE intern who has completed two years of law school and has experience in AIDS-related

legal issues in the United States has begun to work with other organizations in Malawi to explore how the inheritance rights of widows and orphans might be protected. She is participating in the National Task Force on Orphans' legal subcommittee, which is drafting legislation based on the policies developed by the Task Force. COPE has promoted a national conference to review laws related to orphans, which has been funded and is to be held in March or April 1997.

Progress Toward Objectives

Of a target of 20 private sector institutions and individuals, nine have made cash or in-kind contributions to COPE.

COPE exceeded its target of training 25 Ministry of Health staff in home-based care; as of the end of September, 29 had been trained. COPE has trained 123 GOM service providers and policy makers, NGO staff, and community members in children's psychosocial development; the target is 200.

The targets for presentations at professional meetings (1) and placement of American university-sponsored interns (2) have been reached. Two Malawian students were to have been placed with COPE, but the closing of the university (due to a faculty strike) prevented their placement.

Finally, one regional staff exchange of a targeted three has been held.

Impacts

Through advocacy with the Ministry of Education, COPE secured admission to government schools for 14 COPE secondary school students who were originally admitted to more expensive private schools.

Coordination and Collaboration

COPE's advocacy and training efforts have brought its staff into contact with a large number of other NGOs, government personnel, private sector individuals, elected officials, and leaders of religious organizations.

Alternative Approaches

Advocacy and training activities can pay dividends by mobilizing a broader range of actors to respond to HIV/AIDS-affected children and families. However, because the program's overall

Review of the COPE Program

cost per beneficiary far exceeds a level that can be taken to scale, COPE staff need to use careful judgment in deciding how to invest their time. Any advocacy efforts should have a clearly defined objective and a reasonable chance of achieving a significant result.

A MISSING PIECE: SUSTAINABLE IDENTIFICATION, MONITORING, AND SUPPORT FOR THE MOST VULNERABLE CHILDREN

The households in a community severely affected by HIV/AIDS are continually changing. The earliest affected have developed ways to cope or reconstituted themselves so they can. They live alongside people previously unaffected who have begun to suffer hardships. This pattern has three important implications for programming:

- C Because the problems and capacities of affected households vary, no one intervention can be expected to benefit all.
- C Ongoing, community-based monitoring is needed to identify the most vulnerable children and households to which these interventions can be directed.
- C The overall level of need can be expected to increase over a period of years and may remain high.

Dependence on Implementation by Field Workers

The team is concerned that primary responsibility for identifying those most in need and linking them with relevant interventions has been with the program's 11 paid field workers. SC-US's hope has been that most of these workers will eventually be taken on by MOWCACDSW and, thereby, continue their work. This is a questionable strategy for sustaining support to AIDS-affected children and families for three reasons.

First, although the Ministry has expressed some interest in employing the field workers, it is in a period of retrenchment and decentralization, and it appears that the District Assembly (rather than MOWCACDSW), that will control the purse strings for local services and decide which social welfare positions will continue. Also, employing any of the field workers would require an increase in the district's budget for social welfare activities at a time when government functions are being cut back.

The second is the requirement that candidates for social welfare assistant positions must have completed an 18-month social work course. None of the COPE field workers have this formal training. SC-US has proposed that this requirement be waived in view of their field workers' in-service training and work experience, but it remains an issue.

Third, even if some of the field workers were employed, they could not be expected to continue working in the villages to which they have been assigned by COPE. Mangochi District, with some 609,000 residents, currently has only three social welfare staff: a social welfare officer and

two social welfare assistants. Any conceivable increase in social welfare personnel would not permit continuation of the intensive work that COPE's field workers have been doing at household and village levels. Anticipating that the government might hire its field workers is not an appropriate a phase-out strategy for Mangochi and Namwera, much less in a model that could be implemented at scale. COPE needs to develop an approach to identification, monitoring, and support to vulnerable children and families that is community-based.

Need for Community-based Action

The COPE proposal included an objective for promoting "community responsibility and participation in establishing and monitoring foster placements for displaced and orphaned children." Because few, if any, children were identified as being in need of foster care, SC-US dropped this objective. In doing so, however, it left out the approach that offered the most promise for sustainable identification, monitoring, and assistance to vulnerable children: a child advocacy committee in each village that would "develop a system for increasing support for extended and substitute families."

This approach sounds very much like the community-based orphans visiting programs that have been established in Uganda, Zambia, and Zimbabwe.³⁰ In these community-based initiatives, volunteers identify the orphans (and sometimes vulnerable children who are not orphaned) in the areas where they live, visit them regularly (e.g. every two weeks) to monitor their situation, mobilize community resources, provide material assistance when available from an NGO, and notify child welfare authorities when children are at extreme risk. These grassroots programs have been supported and in most cases initiated by a national NGO.

Recognizing this need for a more community-based approach, the COPE Senior Project Manager indicated that he intended to work more with existing structures (such as religious groups) in the Namwera communities than has been done in Mangochi town. His intention is to promote community involvement in needs identification and planning from the beginning, with a view to fostering community commitment to address needs and problems as well as ownership of the interventions. This approach should have a better chance of producing sustainable results than the hands-on approach that field workers have taken in the Mangochi town area.

The team encouraged COPE staff also to explore how the program might help catalyze and support the kinds of community-based initiatives that MOWCACDSW and UNICEF intend to promote at the village level to build family and community capacities to cope with the effects of AIDS. These include community-based child care centers, which could help free time in households caring for orphans for income generation and other tasks. MOWCACDSW and UNICEF also anticipate the formation of community AIDS committees whose activities could include analysis of the needs of vulnerable children and the implementation of volunteer efforts

to address the needs. Given the limited staff and logistical resources of MOWCACDSW, the help of NGOs such as SC-US will be needed to initiate and support such action. Also, by cooperating in this program, SC-US would gain government sanction for its efforts to promote community-based systems of care. Putting its efforts in the context of a nationally endorsed government initiative could help legitimize in the eyes of traditional leaders and community residents the kinds of volunteer-based initiatives that COPE intends to promote in Namwera.

Coming to Terms with a Dilemma

SC-US and other organizations seeking to respond in sustainable ways to continually emerging needs and problems among children and families affected by HIV/AIDS face a very difficult dilemma. On the one hand, they require funding to function. To secure funding an organization must present a credible proposal in which it commits itself to carry out specific activities and achieve measurable results, usually a relatively short time frame. On the other hand, an NGO faces the reality that genuine community ownership and commitment take time to build, may take different forms than the agency anticipated, and typically require at least a minimal level of ongoing material and/or moral support.

Faced with this dilemma, NGOs typically compromise by promoting volunteer participation in the activities that they organize, hoping that the volunteers will take over the efforts and keep them going. Such continuity is generally not achieved, however, because the community sees the activities not as its own but as initiatives the NGO wanted. Although short-term, measurable results are achieved, sustainability is not. COPE has already experienced the problem of volunteer burn-out in the implementation of COPE.

In Namwera, SC-US should take the opportunity to experiment with different approaches, with a focus on facilitating the emergence of community-owned efforts. The proposal and logframe notwithstanding, USAID/Malawi and DCOF would do well to encourage SC-US to do so. Eight months may prove too short a period for this type of approach to succeed, and its effectiveness will only be judged over a period of years. Nonetheless, the only meaningful response to ongoing HIV/AIDS-related problems in the long run, will be one that better enables families and communities to cope more effectively. SC-US, for its part, should explore whether it can secure resources to provide longer term, if limited, ongoing support and encouragement to affected communities through its child sponsorship component or other sources.

Building sustainable responses at the community level should require relatively small amounts of funding per community, provided over as long a period as possible. National and local NGOs may have an advantage over international NGOs because their overhead costs tend to be lower and their involvement may be less likely to stimulate expectations of substantial and sustained funding or employment among community members and leaders.

GOING TO SCALE

The number of children orphaned and families seriously affected by HIV/AIDS in Malawi is already large and will increase substantially for several years. Unless their problems are addressed on a large scale, extensive socioeconomic difficulties can be expected--perhaps even social instability. It is imperative that all parties in a position to act--the government, donors, international organizations, NGOs, businesses, civic associations, religious bodies, and community groups--work together to initiate major efforts to significantly reduce these growing problems. The primary significance of pilot initiatives like COPE is the extent to which they can help identify ways to do so.

TARGETING

Cost-effective responses to the most critical needs must be rapidly developed. But even if this is done, it is unlikely that sufficient resources will be available for their implementation in every community. It will be necessary to direct available financial and material resources to the geographic areas where families are having the most difficult time coping and within these areas to the most vulnerable children and households.

The "Family and Community Care Situation Analysis" that UNICEF Malawi commissioned in 1994 represents important background work for such targeting. Its findings, however, are presented with a broad brush. Additional efforts are needed to identify the specific areas where children are at greatest risk, so assistance can be directed where it will do the most good.

The 1997 census, now in a preliminary stage, offers an opportunity for Malawi to collect information on orphans to permit effective geographic targeting.³¹ The GOM has defined an orphan as a child (below 18 years of age) one or both of whose parents are dead. By collecting information on the status of parents (father: living/dead; mother: living/dead; both parents: living/dead) and reporting findings on orphans at the subdistrict level, the census can provide a valuable snapshot of where these children are concentrated. Areas with higher rates of double orphans (children who have lost both parents) would be of particular concern, as this pattern is most common where the HIV/AIDS epidemic is more advanced and the stress on families and communities is likely to be very high.

As valuable as the census data can be, however, other kinds of information will also be needed for effective geographic targeting. Because AIDS morbidity and mortality will have their most devastating impacts on children and families who are already vulnerable due to other factors, other indicators of poverty, such as rates of infant mortality and malnutrition (if they are considered dependable at the district or subdistrict level), should also be considered. It may be

possible to combine census data on orphans with other statistics to develop a vulnerability index that would identify the geographic areas where problems are greatest. Ongoing monitoring will also be needed because the epidemic will continue to evolve, increasing problems in areas previously less affected.

In addition to such statistical indicators of problems, it is also necessary to consider where relevant services are now being provided. Unlike some other countries, however, Malawi does not appear to have much geographic concentration of NGO activity in response to the needs of orphans.

Finally, and most important, decisions about geographic targeting must incorporate assessments that involve the people in the most affected areas. They are the ones who can say which of their many problems are of the greatest concern. They also are in the best position to identify the children and households at greatest risk. The most vulnerable members of a community are the least likely to make their needs known, and residents are generally much better able than outsiders to assess relative levels of need among households.

INTERVENTIONS

It is not enough to know where to intervene and who should receive priority. Available resources must be used for effective interventions that can be sustained. Interventions to address the needs of children and families affected by HIV/AIDS will be of significant help to the extent that they:

- C build the coping capacities of households, families, and communities;
- C protect and ensure care for the most vulnerable children; and
- C help affected children prepare to support themselves and their siblings.

Experience with COPE and with programs elsewhere suggests that some interventions are more likely to be cost-effective and appropriate to implement at scale. But program planners should not anticipate that one set of interventions should be uniformly implemented in all communities severely affected by HIV/AIDS. It should be possible, though, to identify a range of activities that communities will be able to match with their problems and capacities then assist residents to initiate the ones that are most suitable and to which they are prepared to make a commitment.

Poverty lending programs like GGLS appear to offer good promise. They must, however, be managed by staff with solid training and experience in this type of initiative. A review of solidary group lending and village banking in other countries yielded an average cost per *client*

figure in the \$37-\$55 range, depending on the amount of training and technical assistance provided. (Cost per *beneficiary* would be calculated by dividing the cost per client by the average size of the participating households.) The average cost per dollar loaned was \$ 0.08 - \$0.10.³² FINCA/Malawi's cost falls in the upper end of this range, but the cost has not been calculated for COPE.

In addition to poverty-lending programs, interventions that provide material inputs to support a particular type of income-generating activity may be cost-effective where participants already have most of the necessary skills and have ongoing access to resources and markets. However, externally introduced business initiatives with which participants have little experience typically incur significant costs and have a generally poor track record.

Training for home-based care is a valuable activity, particularly if psychosocial and inheritance issues are addressed as well as physical care. Community-based identification, monitoring, and support of the most vulnerable children are needed. In Zimbabwe, Family AIDS Caring Trust is implementing this type of program.³³ The potential of community-based child care centers, proposed by UNICEF and MOWCACDSW, should be explored.

It should be possible for communities to implement recreation activities inexpensively, but their value as an intervention depends on residents ensuring that isolated and vulnerable children are included. Secondary school scholarships are valuable, but it is not clear whether they could be secured and sustained without substantial ongoing inputs of staff time and matching funds. Drama groups can be used to help raise awareness about needs and problems and convey HIV/AIDS prevention messages. They might also be part of periodic community-based fund-raising efforts. Apprenticeships may have potential if developed in keeping the capacity of the market to absorb those trained.

Interventions to address problems among children and families affected by HIV/AIDS should be integrated (or at least coordinated) with any other efforts to improve conditions in their communities. "Programme Plan of Operations: Care and Nutrition", developed by UNICEF and GOM, provides an important example of programmatic targeting because it addresses the effects of HIV/AIDS on children and families not as an isolated issue, but as one set of factors among others that contribute to poverty and malnutrition. The plan calls for an integrated set of initiatives to address fundamental problems.

Donors, NGOs, and others concerned should consider the country's pioneering "Policy Guidelines for the Care of Orphans in Malawi and Coordination of Assistance" and the "National Orphan Care Programme: 1996-1998" when determining what kinds of interventions to support. Resources should not, for example, be used to establish more institutions to care for children, which the policy guidelines identify as a last resort. Not only does institutional care generally fail to meet children's psychosocial needs, it is very expensive and can increase the

scale of problems rather than help solve them. Where institutional care is available, families under economic stress often use it as a coping mechanism, sending children who would otherwise remain in their care to an orphanage. The more places available in residential institutions, the more children are likely to emerge from families to fill them.

Interventions must be cost-effective, program planners should not spread them too thinly, in an effort to achieve the lowest possible cost per beneficiary. The most critical and basic problems among the households affected by HIV/AIDS are economic. Interventions should be sufficient to make a difference in household food security, for example, and not simply “reach” as many households as possible. Also, the capacity of families to cope is affected by their level of psychosocial distress. Helping reduce this distress can enable them to cope more easily. Hope is one of the most important resources of those affected by HIV/AIDS, and efforts to help build it are critically important.

BUILDING AN ENABLING ENVIRONMENT

In addition to programmatic interventions, there are many indirect but strategically important actions that can be taken at the national level to help build an environment in which HIV/AIDS-affected children and families can cope more easily. In *Children and Families Affected by HIV/AIDS*, a draft UNICEF document that the team provided to SC-US and USAID/Malawi, these national-level actions are identified as:

- C Increasing awareness, understanding, and commitment among policy makers, community leaders, organizations and the public to address problems.
- C Reducing stigma and discrimination with information and the active involvement of leaders, other public figures, and people living with HIV/AIDS.
- C Establishing government laws and policies that protect the most vulnerable children, enable poor children to stay in school, prohibit discrimination based on HIV status, and protect the inheritance rights of widows and orphans.
- C Increasing the effectiveness and impact of programs through information sharing and coordination, developing policies to guide activities, defining roles, and mobilizing resources.
- C Monitoring the epidemic and its effects by regularly collecting and reporting key information on trends.

LESSONS LEARNED

COPE staff identified the following “lessons learned” during the team’s visit:

- C In Namwera, it will be important to work more with existing structures, institutions, and organizations.
- C The program must seek to engender community ownership of interventions.
- C Planning for community involvement must start at the beginning of the intervention period. One important step is encouraging communities to identify their problems and ways to address them.
- C In planning interventions, it is important to pay attention to the seasons when people have more time available for new activities (March-August in Mangochi).
- C Modeling behavior can help change behavior. Concrete actions can be models and catalysts.
- C GGLS has worked to meet the needs for some categories of COPE families.
- C Home-based care has been recognized as needed and important in the communities where training has been done and has had a substantial multiplier effect.

The team offers the following additional lessons learned:

- C Approaches are needed that can be taken to scale. Interventions to address problems among children and families affected by HIV/AIDS should be developed and carried out with a perspective not only on the needs of the immediate community, but also considering the overall scope of the problems in the country.
- C Calculating and monitoring cost-per-beneficiary figures for different interventions can be an important management tool. Budgeting, accounting, and other information systems need to be designed to facilitate calculation of such figures.

RECOMMENDATIONS

The team's recommendations are presented in two groups. The first addresses changes and adjustments for the implementation of COPE, particularly as the staff begins to implement the program in Namwera. The second group is more broadly focused on going to scale with interventions in Malawi.

CHANGES AND ADJUSTMENTS TO COPE

1. The goal of GGLS should be to reach as deeply into the survival economy as feasible strengthening primary-target households' food security and their ability to clothe children and send them to school. Its emphasis should be increasing the amount of cash coming into primary-target households for consumption rather than promoting business growth.

[see pages [9](#), [11](#)]

2. In Namwera, SC-US should work to galvanize or catalyze community-based organizations that can provide a sustainable safety net for the most vulnerable children and households.

Community-based groups should look to occasional fund-raising activities rather than ongoing income-generating activities as a means of generating resources. Community-based orphan visiting programs implemented elsewhere in the region and the community-based child care centers that UNICEF and MOWCACDSW plan to promote should be considered as potential models for or components of this approach.

[see pages [8](#), [17](#), [31](#)]

3. SC-US should explore the possibility of establishing a full-fledged poverty-lending program as a companion piece to COPE instead of negotiating a credit guarantee fund with CBM.

Although such a fund at CBM might enable a few women to borrow directly from the bank, it does not appear that it could engineer an ongoing solution to providing long-term access to loans or savings for women operating marginal income generating activities. Yet it is these very activities that contribute to shoring up household resources—particularly food security—during times of severe economic stress. A new kind of financial institution that molds its product (credit) to respond to the needs of such clients is necessary. Mature lending groups wanting to increase the size of their loans beyond the poverty-lending levels could be linked to the credit union or to WWB.

[see page [14](#)]

4. SC-US should explore the feasibility of carrying out or at least initiating training in home-based care for accompanying family members before patients are discharged from the district hospital.

[see page [22](#)]

5. *SC-US should incorporate into its training for home-based care attention to inheritance issues and the psychosocial distress of patients, caregivers, and children.*

[see pages [iii](#), [v](#), [20](#), [22](#), [27](#)]

6. *To help plan its activities in Namwera SC-US should conduct a simple time and activity study to better understand how women, men, and children use their time in different types of primary-target households. Such a study might be done by observation, interviews, and/or focus group discussions. The findings could be discussed with participants to identify interventions that might reduce the time required for some activities (e.g. gathering firewood) and free time for others (e.g. child care, income-generating activities).*

[see page [8](#)]

7. *SC-US should emphasize recreational activities that can be carried out with locally available materials. Staff might also explore whether sponsorship from local businesses cover the costs of soccer and other recreational activities.*

[see pages [iv](#), [24](#), [26](#)]

8. *To help reduce operating costs, SC-US should simplify the COPE management information system, limiting it to information that staff need to implement and measure the progress and impacts of the program.*

[see page [5](#)]

9. *If SC-US organizes a national conference on orphans, as called for in the COPE proposal, it should be held in collaboration with the National Task Force on Orphans and any other key actors in this area of policy development and programming. The conference should be used as an opportunity to involve agencies and donors not currently active in this area but whose involvement will become increasingly important as the effects of the HIV/AIDS epidemic in Malawi become more severe. The conference should be used to highlight the extent of need throughout the country and as an opportunity to compare and contrast the approaches that different organizations have taken in Malawi and elsewhere.*

[see pages [v](#), [27](#)]

10. *The final evaluation of COPE in 1997 should consider impact and cost per beneficiary information to identify interventions that could be implemented at scale.*

[see pages [ii](#), [6](#), [32](#), [34](#)]

GOING TO SCALE IN MALAWI

11. To promote sustainable approaches, USAID in the future should consider funding one or more initiatives for a period of at least five years to accommodate the relatively slow process of mobilizing, strengthening, and supporting community-based initiatives.

[see page [32](#)]

12. To facilitate the calculation of costs per beneficiary of program activities, budgets should be constructed with cost centers that correspond to the activities whose costs are to be monitored and staff activities tracked in relation to these activities.

[see pages [ii](#), [7](#), [37](#)]

13. USAID/Malawi and SC-US should advocate that the GOM record information on orphanhood in the 1997 census and report this data to provide a better basis for targeting and planning interventions. The information should be collected so that it can be presented by the status of parents (mother: living/dead; father: living/dead; both parents: living/dead), age of children (for each year of age, 1-17 years), and subdistrict of residence.

[see page [33](#)]

14. The National Task Force on Orphans should organize a collaborative process to identify as specifically as possible the geographic areas within Malawi that should receive priority attention for interventions that address the needs of children and families affected by HIV/AIDS.

[see page [33](#)]

15. Since impacts will change as the epidemic progresses, the task force should also establish an ongoing monitoring system that will permit the periodic adjustment of geographic priority areas.

[see page [33](#)]

APPENDIX 1

SCOPE OF WORK OF THE DCOF TEAM

Focus

The primary focus of the team's visit is to be the COPE program of Save (US) in the Mangochi District. The team will not evaluate the program, but review it in order to make any recommendations that may be appropriate regarding its operation. The team's initial review of the situation of children and families in Malawi affected by HIV/AIDS is intended to provide a context for reviewing the COPE program and may also have relevance to other USAID-funded program activities in Malawi, either under way or contemplated.

Activities to be Undertaken by the Team in Malawi

1. Prepare a concise overview (from available written material and key informant interviews) of the impact of HIV/AIDS on children and families in Malawi generally and with particular attention to the communities in Mangochi District where the COPE program is being implemented. Information gathering should include contacts with key ministries/departments (e.g. those responsible for health, women and children's affairs, education, social welfare, agriculture, credit/small-scale economic activities); international organizations (e.g. UNICEF, WHO); and NGOs identified by the mission as having significant experience in assessing and/or addressing problems in this area.
2. Review the goals, objectives, and approaches of COPE as well as its specific activities in relation to the identified problems of HIV/AIDS-affected children and families in the target area and the experience of similar programs in other countries, with a view toward identifying ways it could increase its impact or effectiveness. The team is expected to focus more on substantive program issues than administrative or management issues and to identify the COPE program's progress toward its objectives. Its review should include an assessment of the degree and effectiveness of the COPE program's coordination and/or collaboration with relevant ministries of the Government of Malawi, international organizations, and local and international NGOS.
3. To provide a local comparison with the COPE program the team is expected to visit one or more programs addressing problems similar to those addressed by COPE but implemented by a body(ies) other than Save (US).
4. Identify any lessons learned by COPE or other programs visited that may have applicability to programs for children and families affected by HIV/AIDS outside Malawi.

Reporting

In addition to the summary to be presented during the team's debriefings with the USAID mission and Save (US) personnel in Malawi and to DCOF personnel on return to the United States, the team is to prepare a full written report of 20-30 pages addressing activities 1-4, above. It is to be submitted to DCOF by the team leader within 14 working days of the team's return to the United States.

APPENDIX 2**ITINERARY AND CONTACTS****ITINERARY AND CONTACTS**

Date	Activity	Participants
Oct. 6	Team's arrival in Lilongwe	John Williamson (JW), Jill Donahue (JD)
	Initial discussions with SCF staff	Mr. Stanley Phiri (SP), COPE Program Director, SC; Mr. Joe Kumadzulo (JK), Economic Coordinator, COPE, SC; JW; JD
	Informal discussions with UNICEF staff at the Lilongwe Hotel	Mr. Mark Connolly, Children in Especially Difficult Circumstances, New York; and Mr. Rick Olson, AIDS, Malawi
7	Discussion of schedule	JW, JD, SP, JK
	Review of SOW and plans for visit at USAID mission	Ms. Joan La Rosa, Chief, Health, Population, and Nutrition Officer, USAID/Malawi; Mr. Maxon Nyrongo, Health, Population, and Nutrition Office, USAID/Malawi; Mr. Ken Rhodes, outgoing National Director of SC Malawi Office; Mr. Tom Krift, incoming National Director of SC Malawi Office
	Participation in UNICEF East and Southern Africa AIDS Network meeting at the Lilongwe Hotel	JW, JD, SP
8	Discussion at USAID mission	Mr. Kurt Rochman, Agriculture Development Officer, USAID/Malawi; JD; JW; SP; JK
	Discussion at UNDP office	Mr. Peter Kulemka, National Program Officer, UNDP; JD; JW; SP; JK

	Discussion at Support to AIDS and Family Health (STAFH) Office	Dr. Dorothy Namate, Research Associate, STAFH; JD; JW; SP; JK
	Discussion at the office of the National AIDS Control Program	Dr. Leonard Chitsulu, Program Manager; JW; SP
	Discussion at office of Joint United Nations Programme on HIV/AIDS (UNAIDS)	Ms. Angela Trenton-Mbonde, Country Programme Advisor, UNAIDS; JW; SP
	Discussion at Lilongwe Hotel	Mr. Olson, JW, JD
9	Discussion at Action Aid office	Ms. Janet Duffield, Project Support Officer, Action Aid; JW; SP
	Discussion at UNDP office	Mr. George Zimalirana, Program Officer; JW; SP
	Departure from Lilongwe	JD, JW, SP, JK
	Visit to Balaka Catholic Church (BCC) AIDS program	Ms. Ethel Banda, Distant Adoption Coordinator, BCC; Ms. Susan Clasby, Peace Corps Volunteer; Ms. Bertha Nasoro, Coordinator, COPE; Mr. Lewis Clasby, Field Worker, COPE; JC; JW; SP; JK
	Arrival in Mangochi	JD, JW, SP, JK
10	Briefing on COPE at the SC guest house	Ms. Joan Duncan, Regional Advisor for Children in War and in Especially Difficult Circumstances, SC; Mr. Charlie Pieterick, consultant, SC; Ms. Suzanne Alwan, Lemkin Fellow (focus on legal issues); Mr. Mark Lorey, Hart Fellow (focus on MIS and program development documentation); SP; JK; JW; JD
	Discussion with leaders and residents in Chipalamownada Village and observation of COPE-initiated recreation activities	Village Counselor; Mr. Rington Taibu (RT), Area Mobilizer, SC; Mr. Idrisa Abasa, Field Worker, SC; SP; JW

	Discussion with leaders and residents in Mtalimanja Village and observation of COPE-initiated recreation activities	Village Headwoman Mtalimanja; Ms. Precious Kabewa, Field Worker, SC; RT; SP; JW
	Discussion with leaders and residents in Ngoyi Village and observation of COPE-initiated recreation activities	Village Headman Ngoyi; Ms. Charity Kachione, Field Worker, SC; RT; SP, JW
11	Discussion at the District Commissioner's office	Mr. W. Potani, District Commissioner, Mangochi District; Head Clerk; Senior Human Resources Management Officer; SP; JD; JW
	Discussion with Dimba garden beneficiary household in Mwichande Village	Wife, children, and friend of the principal beneficiary; Headman Mwichande; Mr. Winford Kaphiri, Agricultural Trainer, SC, SP, JW, JD, and other SC staff
	Discussion with Dimba garden beneficiary household in Misi Katema Village	Head of beneficiary household; Headman Misi Katema; Mr. Kaphiri; Ms. Veronica Kananji, Field Worker, SC; SP; JW
	Discussion at the Ice Cream Den	Ms. Duncan, JW
	Meeting with GGLS group in Mbaluku Village	15 group members; JK; JD; JW
12	Review of project logframe and MIS	Mr. Pieterick; Mr. Lorey; Mr. Samuel Kamanga, Data Information Officer, SC; SP; JK; JD; JW
14	Discussion regarding current issues and future directions for COPE and for addressing the needs of children affected by HIV/AIDS in Malawi at the Palm Beach Hotel	SP, JW, JD
	Meeting to discuss methods for calculating cost per beneficiary and to test innovative training tool for introducing group solidarity lending	Ms. Alwan, Mr. Lorey, SP, JD, JW
15	Discussion at District Office	Mr. Francis Blackchide, Assistant District Education Officer; JW;SP

	Visit to the home of a caregiver and patient in Chipalamawamba Village	Mr. Abasa, RT, JW
	Discussion with leaders and volunteers at the Mangochi Islamic Center	Sheik A. M. Balla, Principal of the Mangochi Islamic Center; Mr. Nuroeen Kaonde, District Coordinator, Muslim Association of Malawi; JW; SP
	Discussion about home-based care at the Ice Cream Den	Mr. Daud Maulidi, Area Mobilizer, SC; Mr. Donnex Swalleyi, Field Worker, SC; SP; RT; JW
	Discussion about life skills activities at SC office	Mr. Adam Alide, Skills Trainer, SC; Mr. Kizito Mbingwa, Skills Trainer, SC; SP; JW
	Discussion at SC office about lessons learned	SP, JW
	Dinner meeting at Palm Beach Hotel	Ms. Alwan; Mr. Lorey; JW
16	Discussion at Mangochi General Hospital	Dr. Thomas Nyirenda, District Health Officer; SP; JW
	Meeting at the District Social Welfare office	Mr. Dominique Misomali, District Social Welfare Officer, members of the District AIDS Coordinating Committee; SP; RT; JW
	Discussion at the Mpondas Health Center	Nine clinic staff members; Mr. Maulidi; JW
	Discussion at Misi Katema Village	Seven members of the Misi Katema drama group; SP; RT; JW
17	Debriefing with COPE staff	Mr. Pieterick, SC, Ms. Alwan, Mr. Lorey, JD, JW, SP, JK
	Travel to Lilongwe	JD, JW, SP
	Debriefing at Lilongwe Hotel	Ms. La Rosa, JD, JW
18	Debriefing at Lilongwe Hotel	Ms. Duncan; Mr. Justin sOpoku, SC-US Regional Director; SP; JD; JW
	Departure for the United States	JW, JD

NOTES

1. USAID/Malawi “Background Information: Politics and Economics in Malawi,” p. 1.
2. USAID/Malawi, “Results Review: FY 1995,” p. 11.
3. Although the original proposal set a target of 150 for vocational training, SC-US decided this was unrealistic, given the limited number of artisans who might take on apprentices in the target villages, and reduced the target to 50, which is specified in the logframe.
4. “Malawi,” Microsoft *Encarta*, 1994.
5. USAID/Malawi, “Background Information: Politics and Economics in Malawi,” p. 1.
6. USAID/Malawi, “Results Review: FY 1995,” p. 12.
7. USAID/Malawi, “Background Information: Politics and Economics in Malawi,” p. 1.
8. USAID/Malawi, “Results Review: FY 1995,” p. 9.
9. USAID/Malawi, “Background Information: Politics and Economics in Malawi,” p. 1.
10. USAID/Malawi, “Results Review: FY 1995,” p. 3.
11. *The 1995 Grolier Multimedia Encyclopedia*, version 7.0.
12. USAID/Malawi, “Results Review: FY 1995,” p. 21.
13. Malawi AIDS Control Program, AIDS Secretariat, Ministry of Health, “AIDS Cases Surveillance Annual Report 1995,” p. 1.
14. O. L. Kaluwa, et al., “1995 Sentinel Surveillance Report, Appendix II,” National AIDS Control Program Malawi, p. 1.
15. USAID/Malawi, “Results Review: FY 1995,” p. 11.

16. Bimal K. Lodh, "The Demographic and Economic Impact of HIV/AIDS in Malawi: 1987-2022," prepared for USAID Malawi, November 1995, table 21(D).

17. Malawi's "National Orphan Care Program: 1996-1998" cites WHO as estimating that at least 5% of African children were orphaned *before* the HIV/AIDS pandemic began. Data from the 1991 Ugandan census, for example, found that 11.57% of all children age 17 years or less had lost one or both parents. Malawi and Uganda have similar HIV prevalence rates as well as ratios of rural to urban population. While Uganda's HIV/AIDS epidemic may have started sooner than Malawi's, it seems likely that it is less than six years ahead. It therefore seems reasonable to assume that the proportion of children orphaned in Malawi in 1996 is similar to that in Uganda in 1991.

18. Estimate provided by the Mangochi district office.

19. One head of household who was caring for her four grandchildren and her daughter, who was ill, said that she had to spend about five hours (and walk about 10 kilometers) every three days to collect firewood for the household. If she were to use a fuel-efficient stove, it should be possible to reduce significantly the amount of time she has to spend gathering firewood. SC-US indicated that fuel-efficient bucket stoves had been successfully introduced into refugee camps in Namwera and that some local people had also started using them.

20. International Food Policy Research Institute, See "Rural Financial Markets and Household Food Security: Impacts of Access to Credit on the Socio-Economic Situation of Rural Households in Malawi," September 1996."

21. MkNelly and Dunford in their literature review ("Are Credit and Savings Services Effective Against Hunger and Malnutrition?" *Freedom from Hunger*, February 1996.) divide borrower groups into three levels: survival economy, microenterprise, and small enterprise, each with different economic goals and financial needs. Credit that targets those in the survival economy is referred to as "poverty lending." Lassen, as cited in the same report, indicates that, "With poverty lending it is legitimate to support sizes and types of activities (e.g., petty trading) and uses of surplus (to feed one's family) that are not promoted with producers and firms at higher levels on the economic ladder." In addition, Lassen points out that although the target groups may differ, poverty lending and microenterprise credit follow the same financial principles and methods.

22. B. MkNelly and C. Dunford, "Are Credit and Savings Services Effective Against Hunger and Malnutrition?" *Freedom from Hunger*, February 1996.

23. See Save the Children/UK, "Living on the Edge, A Study of the Rural Food Economy in the Mchinji and Salima Districts of Malawi," March 1996.

24. “Microenterprise credit,” “village banking,” and “microcredit programs” all essentially terms refer to similar programs.

25. It was not entirely clear to the team if the SC-US model is meant to target as deeply into the survival economy as do the COPE program’s economic interventions. Even though poverty lending follows the same financial principles as microenterprise credit, it targets a different socioeconomic level. Therefore, COPE’s adaptation of the GGLS model should reflect the economic goals and financial needs of the program’s primary-target households. Some policies and procedures therefore may differ slightly from the original model.

26. Generally, it is dangerous to make too strong a connection between increased income and improved nutritional status. For example, “stunting” in Malawi has been attributed more to problems with the frequency of feedings for children than to a genuine lack of food. It is likely a sensitization process needs to take place before nutritional practices change. See UNICEF’s Five-Year Plan, 1996.

27. See Save the Children/UK, “Living on the Edge, A Study of the Rural Food Economy in the Mchinji and Salima Districts of Malawi”, March 1996.

28. Since weekly meetings take place in the afternoon after the women’s business operations wind down, the money collected would have to remain with the group’s treasurer at least overnight.

29. The original proposal set a target of 150 for vocational training. However, SC-US decided this was unrealistic, given the limited number of artisans who might take on apprentices in the target villages, and reduced the target to 50, which is specified in the logframe.

30. See *Action for Children Affected by AIDS: Programme Profiles and Lessons Learned*, UNICEF (New York) and the World Health Organization (Geneva), 1994, pp. 23-28 and 44-48; and G. Foster, et. al., “Supporting Children in Need Through a Community-based Orphan Visiting Programme,” *AIDS Care* (1996), vol 8, no. 4, pp. 389-403.

31. The 1977 census reported information on orphans in Malawi, but the 1987 census did not.

32. Charles Waterfield, “Designing for Financial Viability of Microenterprise Programs,” Mennonite Economic Development Associates, March 1993, p. 44.

33. G. Foster, et. al., “Supporting Children in Need Through a Community-based Orphans Visiting Programme,” *AIDS CARE* (1996) vol. 8, no. 4, pp. 389-403.